CONTRACT HEALTH SERVICES

Indian Health Service Clinical Services	FY 1999 Enacted	FY 2000 Final Appropriation	FY 2001 Estimate	Increase or Decrease
Contract Health Services				
A. Budget Authority	$385,801,000	$406,756,000	$447,672,000	+$40,916,000
B. FTE	0	0	0	0
C. Gen. Med & Surg. Hospitalization: ADPL	245	248	252	+4
D. Ambulatory Care: Outpatient Visits	482,600	490,700	541,600	+50,900
E. Patient & Escort Travel: One Way Trips	35,200	35,900	39,600	+3,700
F. Dental Services	59,800	60,600	66,900	+6,300

PURPOSE AND METHOD OF OPERATION

Program Mission and Responsibilities

The IHS Contract Health Services (CHS) program supplements the health care resources available to eligible American Indian and Alaska Native (AI/AN) people with the purchase of medical care and services that are not available within the IHS direct care system. The IHS purchases both basic and specialty health cares services from local and community health care providers, including hospital care, physician services, outpatient care, laboratory, dental, radiology, pharmacy, and transportation services such as ground and air ambulance. The CHS program also supports the provision of care in IHS and tribally operated facilities, such as specialty clinics, e.g., orthopedics and neurology, and referrals to specialists for diagnostic services.

The CHS program is administered through 12 IHS Area Offices that consist of 66 IHS-operated Service Units and 84 tribally operated health programs. Although the IHS facilities include three major medical centers, most of the IHS and tribally operated facilities are small rural community hospitals and health centers with limited services. In addition, not all tribes have access to IHS or tribally operated facilities. Therefore, the smaller facilities and those Areas with few or no direct care facilities have a higher reliance on the CHS program to provide the needed health care.

The CHS budget also includes a Catastrophic Health Emergency Fund (CHEF) of $18,000,000 in FY 2001, which is intended to protect limited local CHS operating budgets from overwhelming expenditures for certain high cost cases. In FY 1999, the CHEF threshold was $19,500 based on the annual change in the consumer price index as mandated by congressional legislation. The $12 million CHEF budget funded in FY 1999 710 high cost cases in amounts ranging from $5,000 to $558,000. At least 521 cases totaling over $10 million could not be funded in FY 1999.

Best Practices/Industry Benchmarks

Because of high patient demand, the IHS relies on the strict adherence to specific CHS guidelines to ensure that the most effective use of CHS dollars are attained. As much as possible, the IHS pursues negotiated rate agreements with private health care providers to obtain health care at reduced rates, including managed care arrangements. In addition to the CHS requirement for eligibility, the IHS utilizes a medical priority system and considers it self to be the payer of last resort. This means that all patients must exhaust all other health care if eligible, before the IHS can pay. Tribal contractors provide services under the same CHS regulations as the IHS.

In addition, the IHS fiscal intermediary (FI) with Blue Cross/Blue Shield of New Mexico provides a mechanism that provides payment for services in the private sector through a contract. The FI ensures that payments are made accurately and timely according to contractual requirements where applicable, and maintains a centralized medical and dental claims reimbursement system. The FI process functions within the IHS payment policy and meets the standards of the medical industry. Aside to providing payments to vendors, the FI provides program support services that collects, compiles, organizes workload, and financial data, and generates statistical reports to the IHS that support the administration of CHS programs.

Findings Influencing FY 2001 Request

Inflation:

- The medical inflation rate experienced by the IHS in making CHS payments is significantly higher than in the private sector.
- According to the Bureau of Labor Statistics, the Consumer Price Index for Medical Care increased 3.2 percent between 1997 and 1998, whereas for professional care services the IHS FI reported an inflation rate of 9.34 percent for 1998.

Services:

- From FY 1994 to FY 1997, CHS admissions declined by 18 percent, while billed costs per admission increased 19.8 percent.

- From FY 1994 to FY 1997, CHS-purchased professional services declined by 5.5 percent, while billed costs per visit increased 27.2 percent.

Denials:

- From FY 1994 to FY 1997, CHS denials increased 64.6 percent.

Deferred Services:

- The number of reported deferred services increased 42 percent from FY 1994 to FY 1998.

CHEF:

- In FY 1999, CHEF claims exceeded the available $12 million budget by $10 million.
- There were 521 claims for which funds were not available in FY 1999.
- Once the CHEF budget is exhausted, Areas Offices cease to report high cost cases.

ACCOMPLISHMENTS

IHS patients have been able to receive more health care services than the amount of CHS expenditures indicate. This is accomplished through a variety of mechanisms such as alternate resource requirements, and provider discounts/contracts.

Alternate resource (AR) means other third party payers must pay before the IHS will pay. To accomplish this patients are required to inform the Service what type of AR they have and must apply if they are potentially eligible for an AR. Examples of an AR include private insurance companies, Medicare, and Medicaid.

Provider discounts/contracts are agreements to reimburse health care providers at an amount below billed charges. Types of provider reimbursement contracts at a discount include, payment using Medicare methodology, a percent of Medicare methodology, per diem rates, and percent of billed charges (if less than Medicare).

Because of the procedures described above, the CHS program has been able to purchase health care services that total more than twice the amount of the CHS expenditures. The actual amount of billed charges purchased through these arrangements cannot be completely documented because the IHS only has records for payments actually made. For example, payments by Medicaid are considered payment in full in accordance with Federal regulation. Therefore, when a patient is eligible for Medicaid and Medicaid pays the bill there are no charges to be paid by the Service or the patient.

During FY 1998 the total billed charges were $378.4 million. However, the FI paid $173.9 million for this care. The difference resulted from contractual discounts of $125 million, and alternate resource savings of $79.6 million. These figures do not include the additional care paid for through the Medicaid program. Because the Self-Determination Tribes

operate independently from the IHS, we do not have statistics on their savings.

PERFORMANCE PLAN

The following performance indicators are included in the IHS FY 2001 Annual Performance Plan and are primary dependent upon the activities funded within this budget line item for achievement. These indicators are sentinel indicators representatives of some of the more significant health problems affecting AI/AN.

Indicator 2 : Reduce diabetic complications by demonstrating a continued trend in improved glycemic control in the proportion of I/T/U clients with diagnosed diabetes in FY 2001.

Indicator 3: Reduce diabetic complications by demonstrating a continued trend in improved blood pressure control in the proportion of I/T/U clients with diagnosed diabetes and hypertension who have achieved blood pressure control standards in FY 2001.

Indicator 4 : Reduce diabetic complications by demonstrating a continued trend of improvement in assessing the proportion of I/T/U clients with diagnosed diabetes for dyslipidemia (i. e., cholesterol and triglyceride) in FY 2001.

Indicator 5: Reduce diabetic complications by demonstrating a continued trend of improvement in the proportion of I/T/U clients with diagnosed diabetes who have been assessed for nephropathy in FY 2001.

Indicator 6: Reduce cervical cancer mortality and morbidity by increasing the proportion of women in FY 2001 who have had a Pap screen in the previous year by 3 percent over the FY 2000 level.

Indicator 7: Reduce breast cancer mortality and morbidity by increasing the number of the AI/AN female population 40-69 years of age during FY 2001 who have had screening mammography in the previous two years by 3 percent over the FY 2000 levels.

Indicator 8: Improve child and family health by increasing the proportion of AI/AN children served by IHS receiving a minimum of four well child visits by 27 months of age during FY 2001 by 3 percent over the FY 2000 level.

Indicator 12: Improve oral health status by assuring that at least 25 percent of the AI/AN population obtain access to dental services during FY 2001.

Indicator 13: Reduce children's dental decay by assuring that the percentage of AI/AN children 6-8 and 14-15 years who have received protective dental sealants on permanent molar teeth in FY 2001 is increased by 3 percent over the FY 2000 level.

Following are the funding levels for the last 5 fiscal years:

Year	Funding	FTE
1996	$362,564,000	15
1997	$368,325,000	15
1998	$373,375,000	2
1999	$385,801,000	0
2000	$406,756,000	0

RATIONALE FOR BUDGET REQUEST

Total Request -- The request of $447,672,000 is an increase of $40,916,000 over the FY 2000 Appropriation of $406,756,000. The increase is as follows:

Health Disparities - +$40,916,000

The additional requests will be used for the following:

$33,916,000 - New tribes and Health Disparities
$ 6,000,000 - Catastrophic Health Emergency Fund
$ 1,000,000 - Dental Health Program
$40,916,000 Total

Of the increase, $33,916,000 will used to address health status inequities, equitable delivery of health care services, and funding for newly recognized tribes. The AI/AN populations have a long history of disproportionate health problems as compared to the general U.S. population as well as disparities in funding. This increase will address those priority health problems identified by the I/T/Us for FY 2001, including a portion of inpatient services and outpatient services deferred and denied under the IHS medical priority system. In FY 1999 the IHS deferred payment authorization for 84,085 recommended cases and denied 15,844 determined not be within medical priorities. Services and treatment for diabetes, cancer, heart disease, injuries, mental health, domestic/community/family abuse/violence, maternal and child health, elder care, refraction's, ultrasound examinations, physical therapy, dental hygiene, and elective orthopedic services are some examples of cases that are either deferred or denied.

Of the increase, $6,000,000 will be used to supplement the Catastrophic Health Emergency Fund (CHEF) programs. These will e increase the CHEF program from $12 million to $18 million. The CHEF budget has remained at $12 million since FY 1990, in the mean time inflationary costs for medicine and health care has grown substantially as well as the tribal Indian population. The CHEF program continues to enhance the IHS and tribal programs by providing a significant and complementary resource that

supports limited local operating budgets from the over-whelming effects of high cost cases.

Because of funding limitations, not all high cost cases that have a potential for CHEF can be funded. Since FY 1995 the amount of unfunded cases has increased from $8.0 million to $10.0 million in FY 1999. Annually, the Fund is depleted before the end of the fiscal year. Once the CHEF budget is deplete Areas and tribal programs cease to report cases for consideration. The estimated unreported cases are over $15 million making the total need to be more than $25 million. With no additional funds for high cost cases CHS programs have no alternative but to absorb these additional costs from there own resources.

In addition, $1,000,000 will be used to provide services for the dental program to purchase basic and emergency dental services for over 2,000 AI/AN people who do not otherwise have access to dental care from I/T/U clinics. The historic funding level for comprehensive dental services has been insufficient to meet the needs of the Indian population.